EOB Messages (Continued)	
115	This amount plus the amount allowed on previous claim(s) for a part of this service performed at the same time is the maximum allowable amount for this service. If this claim was filed on a participating basis, the beneficiary is not responsible for payment of the disallowed amount.
116	Obsolete procedure code(s) submitted; future claims must contain current procedure code(s) or services will be denied.
117	Obsolete procedure code(s) submitted - service(s) denied; provider must provide correct procedure code(s).
118	No Nonavailability Statement for procedure or service performed.
119	These services require prepayment approval. Please call (insert telephone number) for assistance.
120	Provider is not TRICARE authorized. Requested provider certification information not received.
121	Other health insurance information not provided.
122	Consultation paid as limited office visit. Referring physician not identified.
123	Dental condition not a benefit. TRICARE coverage limited to authorized care required due to a medical condition.
124	Dental authorization not on file.
125	Claim should be submitted to the CHAMPVA Center for processing. (See NOTE, Below.)
NOTE: *EOB Message 125 listed above is an abbreviated version of the following message that the contractor shall use when the contractor denies a CHAMPVA claim when the DEERS response indicates a CHAMPVA alternate care flag "V". (See OPM Part Two, Chapter 1, Section IV.A.2.c.). In the absence of system limitations which preclude its use, the longer message must be used:* *"Claim denied as we are not responsible for processing CHAMPVA claims. Please resubmit the claim using VA Form 10-7959A and forward to: CHAMPVA Center, Post Office Box 65024, Denver, CO 80206-9024. Refer any outstanding questions to the CHAMPVA Center at 1-800-733-8387."*	
126	Medical necessity for standby pediatric physician not documented.
127	Charge reimbursed at the intermediate office visit level.

EOB Messages (Continued)	
128	Provider certification status not documented.
129	Checks not issued for amounts of $.99 or less.(See NOTE, Below.)
NOTE:	*Only applies to contracts awarded in FY 94 and thereafter.*
130	Amount allowed is based on a discount agreement.
131	Reserved
132	Partnership claim not correctly submitted.
133	Family member is no longer eligible, contact your nearest military personnel office or your Administering Secretary.
134	General office visit codes are not used for billing eye exam services. Please resubmit with appropriate codes.
135	Claims must be filed by the VA Medical Center.
136	Charge denied; this Durable Medical Equipment is available for loan from a local MTF.
137	Reserved
138	Services rendered by an unauthorized Marriage and Family Therapist. The provider should contact us for information on how to become a TRICARE authorized provider.
139	Unauthorized Provider. Provider is either an active duty member of the Uniformed Services or a civilian employee of the U.S. Government and is prohibited by Regulation from billing TRICARE or TRICARE beneficiaries.
140	Services, supplies, and equipment associated with palliative care of terminal patient included within hospice all-inclusive rate.
141	Services curative in nature and waived as part of the beneficiary's election to receive care under TRICARE hospice benefit.
142	Claim denied due to hospice's failure to submit requested medical documentation within designated time frame (thirty (30) days from request).
143	Reclassification of hospice care to another rate category based on medical review.
144	Hospice reimbursement reduced to routine home care rate for inpatient respite care exceeding five (5) days.
145	Services paid under the ambulatory surgery prospective payment rates.

EOB Messages (Continued)	
146	This claim is for a Medicare, not a TRICARE eligible beneficiary. No appeal rights are available. Please contact us if you have any questions.
147	Eligibility for Medicare pharmacy benefit not established. Contact DEERS Support Office (DSO) for assistance.
148	Payment reduced for failure to obtain preauthorization. The provider cannot bill for the difference.
149	Have you heard about TRICARE PRIME in Washington and Oregon? In the Prime Program there are no deductibles, no claim forms to file, low copayments, and more. FOR INFORMATION CALL 800-982-0032.
150	This claim has been reimbursed under a capitation agreement with the provider and does not reflect the actual payment for these services.
151	Authorization of cost sharing for the living-related donor liver transplant (LDRDLT) has been disallowed.
152	Your provider may bill you the lesser of its billed charge or 115 percent of the TRICARE allowable charge for each procedure listed on the claim and any noncovered service.
153	The amount allowed has been reduced by ten (10) percent since the provider has refused to submit the claim or has charged an administrative fee for filing the claim. The ten (10) percent reductions and/or the provider's administrative fee are not billable to the beneficiary (patient), patient's sponsor or family, or representative, i.e., guardian or executor.
154	This claim processed without the required Primary Care Manager (PCM) or Health Care Finder (HCF) authorization. All future claims require authorization. To avoid paying at Point of Service (POS) rates, call your local TRICARE Service Center for assistance.
155	This claim cannot be processed without your PCM or HCF authorization. Please contact your local TRICARE Service Center for assistance.
156	Care not provided by network provider. Contact Lead Agent for assistance.
157	Claim does not meet criteria for interim payments. Bill must be submitted at sixty (60) day intervals.
158	Claim for post-operative surgical component has been previously paid. Allowable amount has been reduced to the pre-intraoperative surgical component percentage.
159	Refill denied. Utilization levels have been reached.

EOB Messages (Continued)	
160	Claims processed under Point of Service Option.
161	There was no accompanying documentation with the claim to justify payment of charges on fees exceeding the TRICARE allowed amount for the procedures.
162	The information submitted with this claim does not support an additional allowance.
163	Billed procedure codes rebundled into unbilled procedure code(s).
164	Before receiving care, the patient was informed that TRICARE would NOT provide cost-sharing; or that similar or comparable care the patient received on a prior occasion was excluded. Therefore, the patient is responsible for this charge.
165	TRICARE will pay the claim this time only. Payment will NOT be made in the future for similar or comparable care. Neither the patient nor the provider knew that such care was not medically necessary, at an inappropriate level, or was custodial.
166	The provider knew or was expected to know, that this care was excluded. The patient was not informed that this care was excluded and is not responsible for this charge. If the patient has paid for this service or supply, the patient may request payment from this office by filing a written request, with proof of payment, within 6 months of the date on this notice.
167	*Outpatient observation stay services are not medically necessary.*

e. Information Required on Reverse of EOB Form

All of the following information must be on the reverse of the EOB.

(1) Time Limit for Filing Claims

(a) For services provided before January 1, 1993, all claims submitted under TRICARE must be filed no later than December 31 of the calendar year immediately following the year in which the service or supply was provided.

FOR EXAMPLE:

For Service	File Claims By
January 1, 1992 - December 31, 1992	December 31, 1993

(b) For services provided on or after January 1, 1993, all claims submitted under TRICARE must be filed no later than one year after the date the service or supply was provided or one year from the date of discharge from an inpatient admission for facility charges only.

EXAMPLE:

For Service or Discharge	Received at the Contractor By
March 1, 1994	No later than March 1, 1995
December 31, 1994	No later than December 31, 1995

(c) If your claim was denied because it was not filed on time and you believe you were not at fault, contact us or your health benefits advisor for assistance. In limited circumstances, exceptions may be made.

(2) Sponsor, Patient, or Family Member Not Enrolled or not Eligible on DEERS

If the Defense Enrollment Eligibility Reporting System (DEERS) indicates that the sponsor, patient and/or family member is not enrolled or eligible for TRICARE benefits, you should contact your Health Benefits Advisor or your service personnel office. Claims will be denied if you are not enrolled in DEERS. If the claim was denied and the sponsor has recently gone on active duty, resubmit the claim with a copy of the duty orders and a photocopy of the patient's identification (ID) card (or parent's ID for family member under 10 years of age). If the sponsor is retired, resubmit the claim with the sponsor's retirement papers and a photocopy of the patient's ID card. If the sponsor is deceased, report to any service personnel office to get enrolled or call 800-538-9552 (in California, 800-334-4162; in Alaska or Hawaii, 800-527-5602).

(3) Identification Card (ID) or Eligibility Expired on DEERS

The Defense Enrollment Eligibility Reporting System (DEERS) indicates that the patient's ID card or eligibility has expired. To get a new ID card or extend eligibility, if sponsor is active duty, report at once to your parent service personnel office; if sponsor is retired or deceased, contact any service personnel office. If the claim was denied, when the patient obtains a current ID card, resubmit the claim with a photocopy of the new ID card. In an emergency, call 800-538-9552 (in California, 800-334-4162; in Alaska or Hawaii, 800-527-5602) for assistance.

NOTE:

Contractors may shorten messages (2) and (3) by eliminating the 800 numbers which do not apply to their region(s).

(4) Right to Appeal

If you disagree with the determination on your claim, you have the right to request a reconsideration. Your signed written request must state the specific matter with which you disagree and **MUST** be sent to the following address no later than ninety (90) days from the date of this notice. If the postmark on the envelope is not legible, then the date of receipt is deemed the date of filing. Include a copy of this notice. On receiving your request, all TRICARE claims for the entire course of treatment will be reviewed.

(Contractor's Address)

(5) TRICARE Outpatient Deductible

Effective for care provided on or after April 1, 1991, a TRICARE beneficiary is responsible for the payment of the first one-hundred-fifty dollars ($150.00) of the TRICARE-determined allowable costs or charges on processed claims for covered outpatient services or supplies provided in any one fiscal year. When outpatient services are provided to more than one beneficiary member of a family, the aggregate outpatient deductible amount paid by two or more beneficiary members of the family who submit claims shall not exceed three hundred dollars ($300.00) during any fiscal year. Deductible amounts remain unchanged for family members of active duty E-4s and below; $50.00 per beneficiary or $100.00 for two or more family members. Sponsors/beneficiaries are required to ensure that the proper pay grade/rank is on the DEERS records.

NOTE:

Additional information on the increased deductible is required through calendar year 1991; see Section I.F.4. *After CY 1991, the message above shall be used without additional information. If the contractor chooses to do so, it may revise the message above to include the additional information for calendar year 1991. The contractor may also use a stuffer along with the EOB message above to include the additional information; i.e., the specific categories of beneficiaries affected by the increase, deductible amounts paid to satisfy the current deductible will be applied to the increased deductible, and the deductible year remains unchanged although the deductible increase is effective in April.*

(6) If Payment not Based on the Full Amount Billed

The amount TRICARE may allow is limited by law to the lowest of:

(a) The CHAMPUS Maximum Allowable charge; which for most procedures is equal to the Medicare fee schedule amount; OR

(b) The amount the provider actually charges for the service or supply (to include a discounted charge that a participating provider has agreed to accept under a special program).

NOTE:

The above message may be used on and after May 1, 1992, for "flash" printed EOBs. The current stock of printed EOBs may be used until a new supply is required.

NOTE:

Under some circumstances, the contractor responsible for payment for care in the region will negotiate rates with preferred providers which will be different than the CHAMPUS Maximum Allowable Charge or the provider's usual charge. In such a case, the agreement made by the contracted provider, establishing allowable charge levels will prevail. In this instance, the provider will be participating and payment will be made directly to the provider who will be limited to the agreed charge level in full payment. Current stock of

EOBs may be used until a new supply is printed with the new allowable charge description.

(7) Important Notices

(a) Always Give Your Social Security Number When Writing About Your Claim.

NOTE:

If inquiring about this claim, please provide the Internal Control Number located on the front of this form.

(b) You Can Use This Explanation Of Benefits:

1 As a deductible certificate to show your providers the amount of the outpatient deductible met as of the date of this notice.

2 As a record of bills paid or denied. (If you submitted other medical expenses not shown on this form, you will receive a separate notice.)

3 To collect other insurance. This notice may be used to claim benefits from a secondary insurance policy. Since the insurance company may keep this notice, it is advisable that you keep a record of this information.

(c) Claims payments are subject to the provision that the beneficiary cost-share is collected by the provider, whenever appropriate. The provider's failure to collect the cost-share can be considered a false claim and/or may result in reduction of payment.

(d) If you need more information:

1 Check your TRICARE Standard Handbook.

2 See the health benefits advisor or health care finder at the nearest *Military Treatment Facility (MTF).*

3 Contact us at the address shown on the front of this form.

(e) Please review the services shown on the front side of the Explanation of Benefits (EOB). If you find that the payment consideration has been made for any services that you did not receive or that services were charged by a healthcare professional you did not see, please call the "800" telephone number on the front side of the EOB form.

4. Summary Voucher Information

The summary voucher must contain the following:

a. Form Title: "TRICARE Summary Payment Voucher"

b. Contractor's Name, Address, and Telephone Number.

c. Date of Notice.

d. Name, Complete Address including zip code, and identification number of payee.

e. Name of Beneficiary

f. Sponsor's Social Security number

g. Internal Control Number

h. Date of Service

i. Procedure Code and Brief Description of Service

j. Number of Services

k. Amount Billed

l. Amount Allowed

m. Denial code or reason for the denial. If codes are used, print the corresponding messages on the back of the form. (See Section VI.H.3., above, for acceptable messages.)

n. Deductible applied (the amount applied to the deductible).

o. Summary total to include billed charges, allowed charges, and amount to deductible or cost-share.

p. Total TRICARE payment made by this voucher to the payee.

q. Remarks (Enter longer explanation messages in this space.)

r. Other statements. (See Section VI.H.3.e.). The statements are not required on summary vouchers if a copy of the EOB is included with the voucher.

s. DRG Number

t. Amount paid by other health insurance

5. Explanations of Differences between Billed and Allowed Amounts

Each disallowance or reduction must be clearly explained on EOB's and summary vouchers using codes referring to statements on the reverse or using printed messages on the face. The messages used on the EOB must be compatible with those on the summary voucher.

6. Undeliverable EOB'S and Checks

EOB's, summary vouchers, and checks may be returned by the post office as undeliverable due to such reasons as:

a. Addressee Unknown

b. Incorrect Address

c. Moved, left no forwarding address

d. Addressee Deceased

e. Time Requirements for Research/Remailing

Contractors must accomplish all research for the correct address/addressee and remail within five (5) work days of the receipt of the returned mail. If address correction results in a remailing which is subsequently returned, the same procedures apply as for the first return.

f. Procedures for Handling Returned Beneficiary EOB's, Checks and Development Letters

(1) When a beneficiary's EOB, EOB and check, or development letter is returned as undeliverable due to addressee unknown, incorrect address, or moved, the contractor shall:

(a) Check the claim (hard copy or microcopy) to verify the accuracy of the addressee and address on the EOB or development letter and remail the original document with the correction if an error is found. (Correction of the address on file is also necessary if a discrepancy exists.)

(b) Check the beneficiary eligibility or history file if the claim does not reveal any discrepancy and remail the original EOB, EOB and check or development letter with the new address if one is found.

(c) If the efforts listed above do not result in a different address or name, no further action is required. The EOB or development letter may be destroyed, and, if a check is attached, the check should be voided. Any claim being held pending response to the development letter may be processed to completion at this point even though the 35-day development period may not have elapsed.

(2) When a beneficiary's EOB or EOB and check is returned as undeliverable due to "addressee deceased," the contractor shall verify that the EOB was addressed correctly or whether it should have been issued to the beneficiary's estate or next-of-kin and remail with corrected information, if appropriate. The contractor will develop for an appropriate payee if the beneficiary is deceased. (See Section VI.H.6.f. below.) The EOB shall be destroyed, if no new information can be found. The check should be voided.

g. Procedures for Handling Returned Provider EOBs and Summary Vouchers

When provider EOBs or summary vouchers are returned as undeliverable, the contractor shall:

(1) Review the EOB or summary voucher for accuracy against the provider file and against the claims(s) if the provider file does not reveal any inconsistencies.

(2) Contact the appropriate state licensing agency for the correct address if the above research is unsuccessful.

(3) Remail the EOB or summary voucher within five (5) days of its return when a new address is obtained. (Correct the provider file as appropriate.)

(4) If the above efforts do not result in a different address or name, no further efforts to obtain a correct name or address are required. The EOB may be destroyed and any check should be voided.

h. Procedures for Handling Undeliverable Checks (with or without EOBs)

Procedures for handling undeliverable checks are discussed in Section VI.H.6.f. above. The contractor's TRICARE claims department shall be responsible for researching the correct address and shall follow the procedures in Section VI.H.6.e. through Section VI.H.6.g. above. Additional research must be performed when the check is undeliverable because the addressee is deceased. Contractors must attempt to determine the next-of-kin for a beneficiary by checking the beneficiary eligibility/history file and the claim. When the next-of-kin is identified, the contractor shall send a letter requesting information to enable payment to the legal representative of the estate. If a next-of-kin is not identified, the letter shall be addressed to the estate of the beneficiary at the last known address. (See Section IV.F.1.d., for procedures for payment of claims of deceased providers and applicable state laws.)

I. Claims Splitting

As a general rule under HCSRs, claims should not be split (unless otherwise indicated) but should be reported using the same ICN with a different suffix. Single claims may be split in accordance with the following rules:

HCSRS	1. A claim covering services and supplies for more than one beneficiary (other than conjoint therapy, etc.) should be split into separate claims, each covering services and supplies for a specific beneficiary. This must be split under HCSRs for different beneficiaries.
HCSRS	2. A claim for the lease/purchase of durable medical equipment that is paid by separately submitted monthly installments will be split into one claim for each monthly installment. The monthly installment will exclude any approved accumulation of past installments (to be reimbursed as one claim) due on the initial claim. Must be split under HCSRs.
HCSRS	3. A claim that contains services, supplies or equipment covering more than one contractors jurisdiction shall be split. The claim and attached documentation shall be duplicated in full, and identification shall be provided on each document as "processed" by the contractor and then mailed to the other appropriate contractor having jurisdiction. The contractor splitting the claim counts the remaining material as a single claim, and the contractor receiving the split material for its jurisdiction, counts it as a single claim, unless the split material meets one or more of the other criteria for an authorized split.
HCSRS	4. A claim that contains more than $999,999.99 may be split. This includes DRG claims with submitted charges exceeding $999,999.99.

HCSRS	5. An inpatient maternity claim which is subject to the *TRICARE/* CHAMPUS DRG-based payment system and which contains charges for the mother and the newborn shall be split, only when there are no nursery/room charges for the newborn. See the Policy Manual, Chapter 11, Section 5.1.
HCSRS	6. A claim with procedures which require an ONAS as well as procedures which do not require an ONAS shall be split, because there will be both institutional and noninstitutional services.
HCSRS	7. A claim submitted with both inpatient and outpatient services requiring both inpatient and outpatient Nonavailability Statements may be split, because there would be both institutional and noninstitutional services.
HCSRS	8. Hospice claims that contain both institutional and physician services shall be split for reporting purposes. Institutional services (i.e., routine home care - 651, continuous home care - 652, inpatient respite care - 655, and general inpatient care - 656) shall be reported on an institutional claim format while hospice physician services (revenue code 657 and accompanying CPT codes) shall be reported on a noninstitutional format. See the Policy Manual, Chapter 13, Section 22.1D.
HCSRS	9. A claim submitted on behalf of a nonparticipating provider with dates of service on and after November 1, 1993, shall be multi-suffixed to account for the balance billing limitation based upon the dates of service effective with processed to completion date on or after November 1, 1993.
HCSRS	10. A claim for ambulatory surgery services submitted by an ambulatory surgery facility (either freestanding or hospital-based) may be split into separate claims for (1) charges for services which are included in the prospective group payment rate, (2) charges for services which are not included in the prospective group payment rate and are separately allowable, and (3) physician's fees which are allowable in addition to the facility charges. (See the Policy Manual, Chapter 13, Section 9.1.)

J. Liver Transplant Claims

Benefits are payable for liver transplantation when the service meets the requirements specified in the Policy Manual, Chapter 3, Section 8.5. Provider and reimbursement requirements are also included in the Policy Manual.)

K. Heart Transplant Claims

Benefits are payable for heart transplantation when the service meets the requirements specified in the Policy Manual, Chapter 3, Section 5.3. (Provider and reimbursement requirements are also included in the Policy Manual.)

L. Former Spouses with Pre-Existing Conditions

The former spouse will be coded as ineligible on DEERS. A Memorandum of Authorization issued by the military service must be attached to the claim to provide the period of eligibility and identify the specific pre-existing condition for which TRICARE benefits are authorized. If the Memorandum of Authorization is attached, the contractors shall override the DEERS eligibility response and the INAS and ONAS requirements and process the claim. If the Memorandum of Authorization is not attached, the claim shall be denied as eligibility expired on DEERS. Refer to Policy Manual, Chapter 9, Section 1.1A and 1.1B.

M. Hospice Programs

On a one time basis, contractors shall notify, by letter, all hospice programs certified to participate in Medicare, of the implementation of a hospice benefit under TRICARE (i.e., those hospice programs appearing in the October 3, 1994, Medicare Report, see Policy Manual, Chapter 13, Addendum 4, Exhibit 2). A sample letter is provided at Figure 2-1-A-22. Contractors shall offer the Medicare approved programs the opportunity to become certified by signing the Participation Agreement for Hospice Program Services (see Policy Manual, Chapter 13, Addendum 4, Exhibit 1). Thereafter, the contractors shall follow the guidelines in the Policy Manual, Chapter 13, Section 22.1C for certification of hospice programs.

N. Procedures For Contractor Coordination On Out-of-Jurisdiction Providers

Contractors subject to the requirements of the Automated Data Processing and Reporting Manual (OCHAMPUS 6010.50-M) who are responsible for processing claims for care provided outside of their provider certification jurisdiction (i.e., claim processing jurisdiction is determined by beneficiary residence or jurisdictions based on beneficiary residence and provider location overlap) shall first search available provider files, including the TMA-supplied copy of the TRICARE centralized provider file (to be provided at least weekly), to determine provider certification status, obtain related provider information, and determine if the certifying contractor has submitted a Health Care Provider Record (HCPR) for the out-of-area provider.

1. File Search Unsuccessful

If the file search is unsuccessful, the following procedures apply:

a. The servicing (claims processing) contractor shall request provider information from the certifying contractor and put the claim in controlled development status at the time of the request (e.g., date of telephone contact, fax, etc.).

b. Each contractor shall designate a point of contact as specified in this chapter at Section II.A. who shall be responsible for initiating actions related to such requests and ensuring these actions are timely and well documented.

c. The certifying contractor shall respond within *five (5)* workdays of the request with either a.) complete provider information for the servicing contractor to process the claim and submit a Health Care Service Record (HCSR) in situations when a HCPR has already been accepted by TMA or b.) the information that a HCPR for the provider

certified if such is the case, any special prepayment review status, and the following HCPR data:

(1) Provider Taxpayer Number or Assigned Provider Number

(2) Provider Sub-identifier (may need to be assigned by the servicing if the certifying contractor is not on HCSRs)

(3) Provider Contract Affiliation Code

(4) Provider street address

(5) Provider "pay to" address

(6) Provider State or Country

(7) Provider Zip Code

(8) Provider Specialty (noninstitutional providers)

(9) Partnership data (Partnership indicator, discount percentage, effective and ending dates)

(10) Type of Institution (institutional providers)

(11) Type of reimbursement applicable (DRG, MHPD, etc.)

(12) Per diem reimbursement amount, if applicable

(13) IDME factor (where applicable)

(14) Provider Acceptance Date

(15) Provider Termination Date

(16) Record Effective Date

e. The certifying contractor shall provide additional data upon request of the servicing contractor or TMA to meet internal processing, prepayment review, or file requirements or, to create a HCPR when the certifying contractor is not under the requirements of the Automated Data Processing and Reporting Manual. The certifying contractor shall also provide the pricing information and any special provider reimbursement arrangements (e.g., Partnership) for the servicing contractor to accurately determine the allowable amount for the provider's services if the provider is TRICARE certified.

f. Maintenance of HCPR with an Assigned Provider Number (APN)

g. In all cases when an APN is assigned, the certifying contractor shall attempt to obtain the provider's actual TIN. Within ten workdays of receipt of the provider's TIN, the certifying contractor who is under the requirements of the Automated Data Processing and Reporting Manual shall inactivate the APN HCPR and add the HCPR with the provider's TIN regardless of whether the provider meets TRICARE certification requirements.

h. Provider Correspondence

i. Any provider correspondence which the servicing contractor forwards for the certifying contractor's action or information shall be sent directly to the certifying contractor's point of contact to avoid misrouting.

j. Within one week of receipt, the servicing contractor shall forward for the certifying contractor's action any correspondence or other documentation received which indicates the need to perform a provider file transaction. This includes, but is not limited to, such transactions as address changes, adding or deleting members of clinics or group practices, or changing a provider's TIN.

k. Provider Certification Appeals

l. Requests for reconsideration of an contractor's adverse determination of a provider's TRICARE certification status are processed by the certifying contractor. Any such requests received by the servicing contractor are to be forwarded to the certifying contractor within five workdays of receipt and the appealing party notified of this action and the reason for the transfer. The certifying contractor shall follow standard appeal procedures including aging the appeal from the date of receipt by the certifying contractor, except that, if the reconsideration decision is favorable, the provider shall be notified to resubmit any claims denied for lack of TRICARE certification to the servicing contractor with a copy of the reconsideration response. In this case, the certifying contractor shall ensure a HCPR for this provider is accepted by TMA within one calendar week from the date of the appeal decision.

m. The servicing contractor shall forward to the certifying contractor within five workdays of receipt any provider requests for review of claims denied because the certifying contractor was unable to complete the certification process. The servicing contractor shall notify the provider of the transfer with an explanation of the requirement to complete the certification process with the certifying contractor. Upon receipt of the provider's request, the certifying contractor shall follow its regular TRICARE provider certification procedures. In this case, no basis for an appeal exists. If the provider is determined to meet the certification requirements, the special provider notification and HCPR submittal requirements in Section VI.N.2.l. apply.